Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST DAVIDS HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3926

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
54

MFDR Tracking Number
M4-09-6598-01

MFDR Date Received
March 4, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…fair and reasonable reimbursement for the services rendered to this injured worker would not be less than $12,884.06. DRG 496 reimbursed @ Medicare rate of 108% = $12,780.66, Implants (rev code 278) reimbursed @ (cost $94.00 + 10%) = $103.40, Adjusted Amount Due: $12,884.00, Less Amount paid: $5,665.47, Payment Due & Requested: $7,218.59."

Amount in Dispute: $7,218.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is Texas Mutual's position that the payment made is in accordance with the Inpatient Hospital Facility Fee Guideline (Rule 134.404 (f)(1)(A); therefore, no further payment is due for the inpatient treatment rendered from 3/5/08 – 3/12/08 …The requestor did not bill separately for implants. Therefore, the Medicare facility reimbursement amount plus any applicable outlier payment is multiplied by 143%. The requestor's payment is based on DRG 538 which was billed on the initial bill and the request for reconsideration bill…Texas Mutual's… payment is consistent with Rule 134.404 Hospital Facility Fee Guidelines for Inpatient Services therefore, no further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 East Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2008 Through March 12, 2008	Inpatient Hospital Surgical Services	$7,218.59	$27.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 6, 2008
   - CAC-W1– WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 468– REIMBURSEMENT IS BASED ON THE MEDICAL HOSITAL INPATIENT PROSEPCTIVE PAYMENT SYSTEM METHODOLOGY
   - 480– REIMBUREMENT BASED ON THE ACUTE CARE INPATIENT HOSPTIAL FEE GUIDELINES.
   - 618– THE VALUE OF THS PROCEDURE IS INCLUIDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - REIMBURSEMENT MADE IN ACCORDANCE WITH RULE 134.404(F)(1). SEPARATE REIMBURSEMENT FOR IMPLANTABLES WAS NOT REQUESTED IN ACCORDANCE WITH RULE 134.404(G).

   Explanation of benefits dated March 9, 2009
   - CAC-W1– WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-W4– NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERAITON.
   - 420– SUPPLEMENTAL PAYMENT.
   - 468– REIMBURSEMENT IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSEPCTIVE PAYMENT SYSTEM METHODOLOGY
   - 618– THE VALUE OF THS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 891– THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.
   - REIMBURSEMENT MADE IN ACCORDANCE WITH RULE 134.404(F)(1). SEPARATE REIMBURSEMENT FOR IMPLANTABLES WAS NOT REQUESTED IN ACCORDANCE WITH RULE 134.404(G).

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. Which DRG applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless
(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. The requestor asserts in their position summary that, "DRG 496 is reimbursed at Medicare rate of 108%..." However, review of the submitted documentation supports that the requestor billed using DRG 538 on the initial bill and again on the reconsideration bill submitted to the carrier. Therefore, the division concludes that the appropriate DRG to be reimbursed is DRG 538. The disputed services will therefore be calculated using DRG 538.
4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation submitted for medical fee dispute resolution, finds the requestor did not submit documentation to support that the carrier received the required billing certification as required under DWC rule 134.404 (g)(1). Documentation found supports that the DRG assigned to the services in dispute is DRG 538, and that the services were provided at St. David's Hospital, 919 East 32nd Street, Austin, Texas 78705. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $3,981.42. This amount multiplied by 143% results in a MAR of $5,693.43.
5. The division concludes that the total allowable reimbursement for the services in dispute is $5,693.43. The respondent issued payment in the amount of $5,665.47. Based upon the documentation submitted, additional reimbursement in the amount of $27.96 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $27.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 19, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		October 19, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.